Gillette (W.R.)

A SUCCESSFUL CASE

OF

LAPARO-ELYTROTOMY,

WITH REMARKS ON THE

INDICATIONS, DANGERS, AND RESULTS OF THE OPERATION.

BY

WALTER R. GILLETTE, M.D.,

VISITING PHYSICIAN TO N. Y. LYING-IN ASYLUM, OBSTETRIC SURGEON TO MATERNITY HOSPITAL, VISITING PHYSICIAN TO CHARITY, AND ST. FRANCIS HOSPITALS.

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XIII., No. I., January*, 1880.

NEW YORK:
WILLIAM WOOD & CO., 27 GREAT JONES STREET.
1880.

A SUCCESSFUL CASE

OF

LAPARO-ELYTROTOMY,

WITH REMARKS ON THE

INDICATIONS, DANGERS, AND RESULTS OF THE OPERATION.

BY

WALTER R. GILLETTE, M.D.,

VISITING PHYSICIAN TO N. Y. LYING-IN ASYLUM, OBSTETRIC SURGEON TO MATERNITY HOSPITAL, VISITING PHYSICIAN TO CHARITY AND ST. FRANCIS HOSPITALS.

Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES OF WOMEN AND CHILDREN, *Vol. XIII., No. I., January,* 1880.

NEW YORK:
WILLIAM WOOD & CO., 27 GREAT JONES STREET.
1880.

A SUCCESSFUL CASE OF LAPARO-ELYTROTOMY,

WITH REMARKS ON THE

INDICATIONS, DANGERS, AND RESULTS OF THE OPERATION.

BY

WALTER R. GILLETTE, M.D.,

Visiting Physician to N. Y. Lying-In Asylum, Obstetric Surgeon to Maternity Hospital, Visiting Physician to Charity, and St. Francis Hospitals.

I WAS called November 8th, 12 P.M., to the N. Y. Lying-In Asylum, to see Mary H., æt. 23; married; native of Scotland, who was in labor with her first child. The House-Physician, Dr. Coughlin, informed me of the general characteristics of the woman, and that he thought there was a narrowing of the superior strait of the pelvis to the extent of two inches.

Looking at her lying upon the obstetric couch, she appeared to be a woman in vigorous health, plump and dwarfed. She gave the history of having always been healthy, and seemed to have no knowledge of her rachitic condition. She merely thought she was small in stature. She was four feet four inches high by measurement. Her femora were incurvated and shortened; her tibiæ long and straight, and set in the middle of the foot, as it were, the heel projecting making it look like a bird's foot. Lying upon her back, she had somewhat the appearance of a turtle in the supine position; the pubic region being broad and flattened, and the perineal region broad. She said she had had more or less pains for a week, but that the waters had discharged eighteen hours previously, since which time she had been in recognized labor. Upon external examination, the uterine tumor was noticed as large, partially anteverted, and freely movable above the superior strait.

There was no fetal heart-sound to be heard; auscultation revealing only the general crackling and hissing of air in the uterine cavity, such as may be heard in those cases of so-called emphysematous uterus, and dependent upon the decomposition of a dead fetus from which the waters have been drained off for a long time.

Upon digital examination, the inferior strait was discovered capacious and expanded, so that, having anesthetized the patient, I was permitted to introduce my whole hand into the pelvic cavity with ease. This was shallow, and led directly to the superior strait, which was reduced in its whole antero-posterior diameter to a slit one and a half inches in diameter.

Through this the lips of the os uteri were pouting and beyond the strait the os seemed dilated about the size of a silver dollar. In the os was a caput succedaneum, through which could be felt a presenting part, which I recognized as the cephalic extremity, but could not determine whether it was the vertex or face.

Recognizing the necessity for immediate delivery by laparo-elytrotomy or Cesarean section, I sent for my colleague, Dr. H. D. Nicoll, and Dr. S. B. W. McLeod, of the consulting staff. Upon their arrival, they examined the case, agreed in the diagnosis, and, with me, considered it a proper one for the operation of laparo-elytrotomy. The patient was anesthetized, and by the illuminating aid of a dim gas-burner and a candle, I commenced the operation, at 3.15 A.M., by the usual incision, namely, from the anterior superior spinous process of the ilium of the right side to the symphysis pubis. There was no difficulty in cutting down to the desired point, but it seemed to me I embarrassed and complicated the operation by not calculating properly for the sunken and retrogressed pubic bone, and thereby making my incision too low down. Two vessels were ligated and one twisted, and the hemorrhage was not serious. Passing the sound into the vagina, I pushed its point up to the opening in the flank, and, cutting down upon it, made the communication with the vagina complete. Enlarging the opening thus made by laceration, I introduced my fingers, and recognized through the os the face presenting in the right mento-iliac position. I dilated the os manually as much as I could, but it was extremely rigid and hard, and could not be pulled open sufficiently even with the blunt hook, whereupon I incised it slightly by means of a curved scissors.

Dr. McLeod now drew the uterus over to the left, so as to bring the long axis in a proper direction for delivery through the opening, and I attempted to apply the forceps. I introduced and applied the left-hand blade without difficulty, but was utterly unable to apply the right-hand blade. This was, no doubt, due to the position of the fetus, which was jammed down by the spastic rigidity of the anteverted uterus against the iliac and pubic bones, with the head and face flexed upon and against the right shoulder. I could not depress the handle sufficiently to make the curve of the blade embrace the head. Dr. Nicoll also made the effort unsuccessfully. I then determined to turn and deliver by the feet. With great difficulty I succeeded in getting hold of the right knee—the only one I could reach—and pulling it down part-way, applied the blunt hook, and delivered the leg. Here I stopped; for, with all the force that I could apply that was compatible with the integrity of continuity of the leg, and with all the assistance which Dr. Nicoll and Dr. McLeod could give in external manipulation, and by endeavoring to push up and dislodge the head toward the left, I was unable to complete rotation. I then performed craniotomy, and evacuated the brain, hoping in this way to reduce the size of the head, so that it could be pushed up out of the way. This was of no avail, for the contraction of the uterus was so great that, upon traction, the flaccid, yielding body of

the dead fetus only doubled the more, and jammed more tightly, notwithstanding our most ingenious efforts. I tried to get the left foot, knowing that if I once could make traction on it, and get the pulley action on the left shoulder, I could most undoubtedly cause the child to rotate, and break up the wedge. This I was utterly unable to do, for I could not reach it.

I then did what I might better have done at first: put on the cephalotribe, crushed the base of the cranium, pushed the presenting leg up, and making traction after reapplying the instrument, and with the aid of a cranioclast holding upon the scalp, delivered without difficulty. The placenta immediately followed, together with the fetid grumous discharges that were pent up behind the decomposing fetus. This I regretted; I should have much preferred delivering it through the vagina, and thus avoided the danger of infecting the wound with septic matter, but it gave me no option. The uterus contracted at once, and there was no hemorrhage of account. The wound in the flank was stitched together with eight sutures (silver), dressed with adhesive plaster and cotton batting over all, and the patient put to bed, with hot bottles at her feet, and eight drops of Magendie administered hypodermically, along with ergot. She did comfortably well all this day (Monday, Nov. 9th), suffering in no way. The temperature did not go above 101° F. The pulse, however, was rapid. Ten grains of quinine every six hours were ordered. The catheter was passed into the bladder, and urine passed through it. Throughout this case the catheter has been passed at proper intervals, and with invariable success. The bladder was *not* opened, as was the case in four out of the seven previously reported operations of laparo-elytrotomy. Nothing of special note occurred until Tuesday, Nov. 10th, 4 A.M., when she woke from her sleep complaining of colicky pains in the abdomen. Morphine was administered. There was no elevation of temperature above 101° F. At 10 A.M., she was tympanitic, although not complaining of pain. Quinine was administered in doses before mentioned, and hot flax-seed poultices applied over the abdomen. The wound looked well, and was exuding but little dark blood from the second external suture.

At 3 P.M., I introduced a rectal tube and considerable wind passed off with great relief. Temperature at this time 100° F. I could not pass the tube above the superior strait, for the reason that the promontory of the sacrum jutted so far forward, and the whole strait projected, so that I could not flex the tube to an angle sufficient to let it pass. Morphine was given her again at this hour. At 8.30 P.M., I called and found her in opium narcosis. The respirations were down to seven per minute, very irregular and stertorous. She was aroused to consciousness with difficulty. The doctor said he had given her another hypodermic injection of morphine at 6 P.M. I remained with her two hours, rousing her and administering coffee and stimulants, until the respirations rose to twelve per minute, when I went home, leaving instructions not to let her respirations fall below this number. Wednesday, Nov. 12th, 10 A.M., she was

progressing favorably, simply drowsy and lethargic from last night's narcosis. Temperature 100°. Wound looked well. In the evening, everything was favorable, and in response to an enema of soapsuds, she discharged a great quantity of wind and was relieved. Thursday, 13th, temp. 99°. Friday, 14th, lactation commenced; temperature 102°, no pain or tympanites. In the evening, the temperature was down to 100°. At midnight, she had a chill, and upon my visit Saturday, 15th, at 11:45, the temperature was 99⅘°, though the wound looked sloughy and was exuding fetid broken-down blood and pus. I immediately removed all the sutures, giving vent to a quantity of fetid liquid, and applied a poultice of flaxseed meal, carbolic acid, and brewers' yeast. Bowels moved twice this evening naturally, and the patient was in a good general condition; quinine, whiskey, and milk freely given. Saturday, 16th, about the same temperature continued at 100° until 10:30 P.M., when it went up to 103°.

At 9 A.M. 17th, it was down to 99°, and the patient was perfectly comfortable. It is needless to report the daily progress of this patient toward recovery from this date, as the temperature has hardly risen above 100°, and there has been no disturbance to occasion the least alarm or worry. The wound, Nov. 21st, has cleaned, and is in the process of repair by granulation. There was no peritonitis. The tympanites was simply due to the empirical dose of morphine, which we are so apt to administer after obstetric operations, and which, by paralyzing the muscular coat of the intestines, must result in the non-discharge of gases, and their consequent accumulation with distention of a tympanitic quality.

The variations of her temperature were due to emotional causes, as she was exceedingly cross and disobedient. There was hardly an untoward symptom other than the sloughing condition which the wound took on at the fifth day.

I think I made a mistake in closing the wound originally, for the purpose of getting union by adhesion. It would seem hardly to be looked for that such union could take place under the circumstances, as it is quite impossible to bring the walls of such a wound in coaptation by the methods at hand. Aside from this difficulty, it had been bathed and saturated by the decomposed fluids which had poured from the uterus at the moment of delivery of the fetus and placenta.

Much time, trouble, and danger would have been avoided if I had treated it as an open wound antiseptically, with a drainage tube passing through the wound into the vagina. The conditions of such a wound are most admirable for drainage, the opening in the vagina being at its most dependent point.

This operation is the eighth that has been performed in the interests of obstetric surgery. To Dr. T. G. Thomas the profession is indebted for the brilliant surgical ability and admirable courage with which he introduced a surgical procedure which, unlike Cesarean section, must in principle and

practice be considered pre-eminently conservative. The two cases of Dr. Thomas, three by Dr. Skene, one by Dr. Hime, of Sheffield, Eng., one by Dr. Edis, of London, and the one here reported, are worthy of a serious consideration, inasmuch as it must soon be determined to what exact class of cases the operation is adaptable. Looking at it from the standpoint of its results, so far it may be considered as having been remarkably successful. It will be remembered that Dr. Thomas' first operation was performed upon a moribund woman in the interests of her child solely, and with the result of saving the child. True it lived but two hours, but the cause of its death was not in the slightest degree associated with the operation, as it died of inherent non-developmental causes. The operation must, therefore, be considered a success in that it demonstrated that the operation was feasible, and had accomplished its purpose. The second case was favorable to both mother and child, both living. Dr. Skene's three operations were undertaken and carried out with results that were promised and foreseen. His first operation was performed in the case of a woman who had already undergone the most serious obstetric procedures, and when she was in a condition when almost any further endeavors must appear hopeless. She had been forty-eight hours in labor, with a pelvis of two and a half inches in diameter. Version and craniotomy had been fruitlessly performed, and her general condition was such that it is hard to conceive that any successful delivery to the mother could be accomplished under the circumstances. In the light of his two succeeding successful operations, is it unfair to presume that laparo-elytrotomy would have saved both the mother and the child in the first case, if it had been performed earlier, before the patient had been brought to death's door by protracted and exhausting efforts at manual and instrumental delivery?

The case of Dr. Hime was fatal from causes entirely independent of the operation. The patient had cancer of the vagina and rectum, between which two passages there was a large fistulous opening. The vaginal canal was narrowed to about two inches by cancerous disease. There was a continuous stinking hemorrhagic discharge from the vagina and rectum, and, in addition to this fearful local condition, she was a chronic alcohol drinker. "A thin, ill-nourished woman, with

a large fatty liver, fatty heart, and a face indicative of her intemperate habits." In this case, the doctor operated almost solely in the interests of the child and saved it, and chose laparo-elytrotomy, "considering that the consequences of Cesarean section in such a case must probably be immediately fatal to the mother." The autopsy showed that there had been no hemorrhage after the operation, the peritoneum was intact, and so was the bladder. The uterus was well contracted, and no damage done except in the tissues intentionally incised. Such a case as this surely cannot be quoted as an argument against the operations performed. Dr. Edis' case was "performed as an alternative to embryotomy in a case of pelvic deformity." The patient had anchylosis of the right hip-joint, was a flabby, unhealthy subject, with extremities that were edematous, and became livid under anesthesia. Forceps had been applied in vain; and when Dr. Edis was called, "a huge thrombus was distending the right labium. The operation was performed in the interests of the child which was saved; there was little hemorrhage, and the bladder was torn on the right side. The result to the mother, in the doctor's judgment, would have been the same if Cesarean section or cephalotripsy had been performed. It is extremely unfortunate that this operation was inaugurated abroad upon two such hopeless cases, but its performance in each case was a demonstration of the preference of the operators for laparo-elytrotomy over Cesarean section and embryotomy, the usual and heretofore established methods of delivery in cases of such a desperate and hopeless nature.

My operation was performed solely in the interests of the mother, as the child was recognized as dead and decomposed.

Aside from the interest in the operation it was, unlike any of the cases of Thomas and Skene, Hime and Edis, of striking peculiarity, in that after laparo-elytrotomy the greatest difficulties were encountered in the delivery. Thus I attempted forceps, version, and craniotomy, and finally had to deliver by cephalotripsy and extraction. It was hardly to have been expected, after I had successfully brought the head into the wound in the flank, that such difficulties could be encountered in its delivery; and in this is the lesson of this case, that laparo-elytrotomy presents but few of the facilities of Cesarean section, although it is free from most of its dangers, and that the

armamentarium of the obstetrician, in performing this operation, must in the future be increased beyond his scalpel, sound, and ligatures, and blunt hook, to that of the forceps, craniotome, cranioclast, and cephalotribe. The presence of a dead, decomposing, and flaccid fetus in a uterus long drained of its waters, in a state of spastic rigidity, is a complication which will perhaps need the intervention of one of these instruments.

If in the future I should meet such a complication as the one related, I would at once resort to the cephalotribe. This I learned in this case, though *a priori* I had no reason to believe I could not deliver by forceps or version. I cannot conceive of the same difficulties to delivery existing with a living or recently dead child, where its firmness and elasticity would give the assistance of leverage in version, and *point d'appui* in the application of forceps.

Perhaps it is too early to specify the domains of this operation from the eight cases reported, but considering it from its standpoint of safety and in the light of its beginning, does it not offer far more hopeful results than the Cesarean section or embryotomy? Thus, in eight laparo-elytrotomies, *four* mothers have been saved, and *six* children delivered alive. Notwithstanding the fact that the four fatal cases were considered hopeless before the operation commenced, can Cesarean section, which is classed as a conservative operation, show more brilliant results?

Eliminating these four cases, as we properly should, can Cesarean section make so favorable a showing?

Does embryotomy, essentially sacrificial to the child, show any equal result with its mortality of thirty-three and a third per cent to the mother?

What are the dangers of this operation as compared to those of gastro-hysterotomy? Dr. Thomas has summed up the chief dangers of this procedure to be: 1st, peritonitis; 2d, metritis; 3d, hemorrhage; 4th, shock; 5th, incarceration of intestines in uterus; 6th, septicemia. The dangers in laparo-elytrotomy are from: 1st, hemorrhage; 2d, shock; 3d, septicemia.

Now, it is a very suggestive fact that, notwithstanding the recognized danger from hemorrhage, in the *nine* cases of laparo-elytrotomy reported (and this includes the case related by Dr. J. T. Everett, of Stirling, Ill., in the Oct., 1879, number of this JOURNAL, of laparo-elytrotomy for the removal

of a calcified fibroid of the uterus), so far there has been no such accident, and possibly future experience will eliminate this danger almost entirely. Certainly we expect no serious hemorrhage from the cut epigastric, which we can always ligate, and the congerie of vaginal arteries, which must be invaded in opening the vagina, thus far have not given us serious hemorrhage, probably because they have been lacerated instead of cut.

The danger from shock is almost *nil*, and from septicemia no greater than that which obtains in any incised wound, open to drainage and antiseptic treatment.

In considering the future of an operation that has had in its inception such brilliant results as laparo-elytrotomy, while we must necessarily be cautious and conservative, we nevertheless have reason to be sanguine, for nothing yet has occurred in its practice which can be other than recommendatory, and in weighing all its possible dangers with those of embryotomy and gastro-hysterotomy, which have been before the profession for centuries, we can see no reason why it must not advance to a position and practice which will render sacrificial obstetric surgery one of the rarest of procedures.